sometimes an individual mandate), emphasizes preventive care and management of chronic diseases, and spreads costs among business, government, and consumers. Yet putting all the pieces together demands compromises that can alienate key constituencies, which is why enacting reform has been so difficult.

In Massachusetts and Vermont, business leaders and health care activists — and Republican governors and Democratic legislatures — were able to reach compromises. In California, reform proponents could not withstand opposition from antitax groups and free-market advocates on the right and single-payer proponents and labor on the left. Moreover, Senate Democrats weren't kept involved in the proposed reform; having invested no political capital, they turned against it.[5]

Twelve states are currently considering health care reform, and Rhode Island's lieutenant governor recently introduced a reform package emphasizing universal coverage and cost cutting. The results of a few state experiments are unlikely to lead to major change. If, however, a dozen or more states enacted affordable reforms, the momentum could trigger national reform, as well as offer models on which it could be based.

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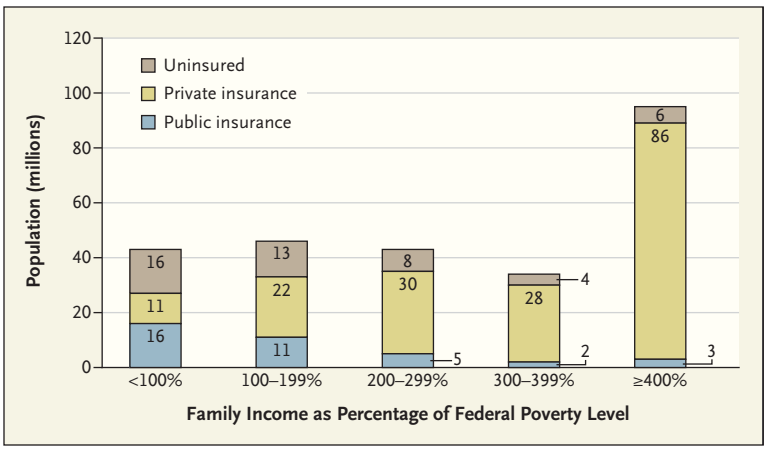
Universal Coverage One Head at a Time — The Risks and Benefits of Individual Health Insurance Mandates

Sherry A. Glied, Ph.D.

The health insurance reform enacted in Massachusetts in 2006 and the proposals of the leading Democratic presidential candidates seek to achieve universal health insurance coverage while relying primarily on private insurance. Achieving universality is a challenge in any system that assigns insurance coverage, whether private or public, to identifiable individuals. The difficulties of finding, enrolling, and accounting for all eligible participants escalate when most of the financing for coverage is expected to come from premiums paid directly to multiple insurers rather than from funds collected centrally by the government through taxation. To address this problem, some reform models incorporate an individual mandate, a legal requirement that every person obtain insurance coverage. The Massachusetts health plan mandates coverage for both adults and children, as Senator Hillary Clinton's proposed plan would do nationally; Senator Barack Obama's plan would require parents to obtain coverage for their children.

Universal coverage that relies on private health plans is hardly unprecedented; several other countries, including Germany, whose health system dates back to 1883, as well as Israel, the Netherlands, and Switzerland, use this model. Neither is the individual mandate unique to the United States. The Dutch and Swiss systems, which, like the U.S. models, rely relatively heavily on premium payments rather than payroll taxes, incorporate such mandates. The individual mandate in the U.S. plans, however, has become a flash point for controversy.

The idea of an individual mandate as a means of achieving universal coverage dates back to the 1993 Clinton health plan. At that time, conservative proponents of expanded coverage argued that the availability of free or subsidized care for the uninsured would generate what they called free riders — people who were aware that inexpensive care would be available in the case of an emergency or a health catastrophe and who would therefore choose to forego



Insurance Coverage of the Nonelderly U.S. Population, by Family Income, 2006.
Data are from the 2007 Current Population Survey, U.S. Bureau of Labor Statistics.

the purchase of private insurance.[1] Though such conservatives rejected a substantial role for government in providing health insurance, they asserted that the free-rider problem legitimated a requirement that everyone hold basic insurance coverage.

The free-rider problem remains a central element in the argument for an individual mandate. Research verifies the existence of such a problem but suggests that its magnitude is quite small.[2] Funds diverted from uncompensated care would not be sufficient to pay for the subsidies needed to cover most uninsured people. Eliminating the free-rider problem through universal insurance might make the health care system more fair, but it wouldn't make it less costly.

Achieving universal coverage is more important as a means of improving the functioning of the insurance market. A fundamental problem in health insurance is that people know much more about their own health than insurers do. Prospective purchasers can — and do — use this information when making decisions to obtain or retain coverage. Insurers respond to this behavior by aggressively seeking out healthier purchasers and discouraging the enrollment of those who seem likely to require costly medical care. This inevitable response drives up the costs of marketing and underwriting coverage, which are substantial components of the very high administrative costs of insurance purchased in the nongroup market. Compelling everyone — whether healthy or sick — to participate in the insurance market may diminish the use of these wasteful insurer tactics. Mandated participation may also make it easier for insurance regulators to limit the extent to which sicker people pay higher premiums by reducing the risk that healthy people will be driven out of the market. Proponents of an individual mandate hope that such a policy would help to reduce the administrative costs of health insurance in the United States to the considerably lower levels found in other private-insurance–based universal systems.

Although the desire to curtail free riding and strategic behavior by insurers provides the philosophical underpinnings of the individual mandate, policymakers' interest in the mandate option owes as much to its fiscal implications. Universal coverage achieved through an individual mandate could cost much less than achieving the same result by giving people subsidies for buying coverage voluntarily.

The individual mandate responds to two lessons learned from previous efforts to expand coverage. First, although most uninsured people would like to have health insurance, the protection it offers against a potential adverse event is not an urgent priority for all of them. Many in this group are healthy. Most have relatively low incomes (see graph) and many other demands on their pocketbooks. A decade and a half of incremental expansion efforts have demonstrated that inducing all uninsured people to take up coverage will require very substantial subsidies — subsidies that might well exceed the cost of the coverage itself.

Compounding this "take-up" problem is a second characteristic of insurance coverage. As the graph shows, even in the group with incomes between 100 and 199% of the federal poverty level, more people currently hold private insurance than are uninsured. Almost all of those who hold private insurance now pay at least a portion of the premium for that coverage. If substantial subsidies were made available for the purchase of new coverage, many who now pay for their own coverage would (eventually) make use of these subsidies instead. Subsidized coverage would crowd out existing private spending, greatly increas-

ing the public cost of an expansion program. The individual mandate gives policymakers a new tool with which to respond to the take-up and crowd-out problems. Increasing the cost of remaining uninsured by imposing penalties in association with a mandate can promote coverage while keeping subsidy levels in check so that they do not lure the privately insured into the subsidized program.

The individual mandate offers new options, but it also introduces risks. The mandate is in many respects analogous to a tax. It requires people to make payments for something whether they want it or not. One important concern is that the government will provide insufficient funds for the subsidies intended to accompany the mandate. In that case, the mandate will act as a very regressive tax, penalizing uninsured people who genuinely cannot afford to buy coverage. This concern has led Massachusetts to create a hardship exemption for its mandate — an escape clause that effectively undoes the mandate if subsidies are insufficient. The ease with which it is possible to lift the mandate if the legislature fails to appropriate funds may make the individual mandate a rather rickety form of universal coverage.

The tax analogy explains another concern about mandates. Conservative proponents of small government fear that special-interest groups will urge legislatures to broaden the minimum mandated benefit package. The relative invisibility of the mandate "tax" may make it easier for special interests to achieve their goals. The mandate, then, would become a means through which special interests use government to force transfers of funds from consumers to the health care sector.

A final concern about mandates relates to their administration. Like taxes, a mandate requires enforcement if it is to be effective. Compliance with taxes, as well as with other mandates in current operation, is never perfect. It varies with the rules and procedures governing enforcement.[3] The nature of insurance makes a health insurance mandate particularly tough to enforce. Taxes can be collected retroactively, but to be effective, an insurance mandate should be in place at the beginning of an insurance term, ensuring that people have coverage when an adverse event occurs. Developing a system to promptly identify and penalize scofflaws will take effort and ingenuity, particularly in our diverse and mobile country. It may require a degree of intrusiveness and bureaucracy that some will find unpalatable. If subsidies are generous and benefits valued, voluntary participation will be high and enforcement problems will be manageable. If subsidies are insufficient or benefits inappropriate, the mandate will be very difficult to enforce and draconian in effect. The risks associated with individual mandates suggest that they are no panacea.

Perhaps the most important benefit of mandates is symbolic. By mandating the purchase of health insurance, governments signal to their citizens that coverage is critical. For many uninsured people as well as their families, communities, and elected representatives, this public commitment to coverage may lead to a reassessment of priorities. Although making mandates functional will be demanding, just passing a mandate may serve an important purpose by moving health insurance higher on the agendas of all these constituencies.

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An audio interview with Dr. Glied can be heard at www.nejm.org.

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